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A CLINICAL CLASSIFICATION OF INSANITY.\*

By F. X. DERCUM, M.D.,

PROFESSOR OF NERVOUS AND MENTAL DISEASES IN THE JEFFERSON MEDICAL COLLEGE, PHILADELPHIA; NEUROLOGIST TO THE PHILADELPHIA HOSPITAL; CONSULTING PHYSICIAN TO THE ASYLUM FOR THE CHRONIC INSANE AT WERNERSVILLE.

The necessity for brevity and condensation will make impossible the discussion of any of the existing classifications. Up to the present time, however, no plan, whether based upon metaphysical or psychological conceptions; upon etiological or symptomatological factors, and least of all, I am sorry to say, upon pathological evidence, has been satisfactory. How such classifications lead us constantly into the field of uncertainty and speculation, how they end in entanglement and confusion, I need hardly point out. Indeed, in my own mind, I long ago abandoned all classification and came to believe that a simple enumeration of the various clinical forms of insanity is all that should be attempted. However, with an increasing experience, I have again changed my views.

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Classifications are of value, and in insanity I believe a clinical classification to be of very great value. Classifications not only illustrate points of view, but they offer definite plans according to which related facts may be placed in proper juxtaposition, and they render possible a comprehensive and co-ordinated conception of the subject. I believe that such a grouping of facts is now possible in regard to insanity.

An increasing experience has also convinced me that the only knowledge of insanity of value to-day is clinical. Pathology has as yet so little to offer, that no intelligible scheme of interpretation is as yet possible, and probably will not be possible for a generation to come. For the present, it seems to me, we must content ourselves with a purely clinical interpretation. A clinical interpretation is not only of practical value, but I hope to show that it is also interesting and scientific. The clinical interpretation of a disease means literally its bedside interpretation, and into such an interpretation there enters every fact at our disposal, near or remote—not only the symptoms presented by the patient, not only his personal history and his family history, not only his sex, his age or epoch of life, but all that we know of the changes in the tissues, all that we know of the course, the duration and the prognosis of the disease in similar cases. In attempting a classification of insanity from the clinical standpoint, therefore, we are guided not by a single series of facts, such as are presented by etiology, or by symptoms, or by the scanty facts of pathology, but by all of these and others combined. It presupposes that we approach the subject from all possible points of view, that we weigh all facts no matter in which category they are found, that we explore all of the converging avenues of truth—in short that we take into account everything that enters into the natural history of the disease we are about to study. Such a method, it appears to me, is not only philosophical and scientific, but is necessitated by the condition of our knowledge of the subject, and I hope to show that it gives rise to clear and logical conceptions in a field where confusion and uncertainty too often prevail.

Again, I have long ago come to the conclusion that insan-

ity must, as far as possible, be approached from the standpoint of practical medicine. Indeed, it has seemed to me most natural to begin the study of mental disorders with the affections with which the general practitioner first comes in contact. For instance, no graduate of medicine practises long before he comes in contact with such an elementary phenomenon as delirium. A child has an attack of fever and the physician observes that it is confused, that it does not recognise its surroundings, that it cries out, that it shrinks, struggles, acts as though it heard strange sounds and saw strange objects. At the same time its restlessness, its cries, its broken and hurried words indicate that the cerebral activity, though perverted, is abnormally aroused. This picture, so familiar, is the picture of simple delirium. There are present illusions, hallucinations, confusion and hurry of thought, fleeting and fragmentary delusions, incoherence. We soon find that these elements are present in every form of delirium, no matter what its origin, and our first logical conclusion is that in these essential particulars all of the deliria are alike. It is perfectly true that some of the deliria present secondary features, dependent upon their causation, as in alcoholic delirium in which visual hallucinations predominate, and yet the fundamental symptoms are always the same. This is the case whether the delirium occurs in a young person or an old person, whether it be mild or whether it be furious.

The deliria naturally separate themselves into the febrile and afebrile forms. The febrile deliria are those which accompany the various acute infections, the exanthemata and the various acute visceral diseases, such as pneumonia. The afebrile deliria are those which are met with as sequelæ of various infectious diseases, as a result of various intoxications and after trauma or shock. Afebrile deliria, as is well known, every now and then ensue during the post-febrile period of one of the exanthemata, for example typhoid fever. As examples of afebrile deliria, due to intoxication, we may instance the deliria from alcohol and from lead.

Under the head of the febrile deliria, it is evident, we must also include, so-called *delirium grave*, or as it is variously

termed, acute delirium, typhomania, acute delirious mania, Bell's delirium. It is a delirium, very active, characterized by a febrile state, the rise of temperature being generally quite high, while there are not present any surface lesions such as are found in the exanthemata on the one hand, nor any signs of visceral involvement, such as pneumonia or meningitis, on the other. I do not desire at this place to enter into a discussion of delirium grave. Neither occasion nor time permits, but I do not hesitate to hazard the opinion that it is a disease due to a specific infection, the bacteria or toxins of which expend their action upon the brain without giving rise to lesions of the cutaneous surface or of the viscera, such as are met with in the exanthemata or acute visceral diseases. It is possible, of course, that delirium grave is an affection which is due to a variety of causes, but a detailed study of the facts will, I believe, negative such a view.

To repeat once more, the various deliria separate themselves into

First, Simple Febrile Delirium.

Second, Specific Febrile Delirium, (which is variously known as Bell's delirium, delirium grave, acute delirium<sup>1</sup>, typhomania, and acute delirious mania.)

Third, Afebrile Delirium.

Delirium is essentially an acute mental confusion of relatively short duration—a few hours, a few days, or at most a week or two. Naturally the morbid state which is most closely allied to delirium is the one in which confusion is less active, but more prolonged. Such a state is found in the prolonged confusion which every now and then comes on in infectious diseases after fever has subsided. It is seen typically in the confusional insanity following typhoid fever, influenza, erysipelas, acute articular rheumatism, the puerperium, profound exhaustion, trauma, surgical shock, etc. Into its causation there enter especially two factors, first, the toxins of infection or other poisons, and secondly, profound and persistent exhaustion. Its symptoms do not differ in any essen-

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<sup>1</sup>All of the deliria are acute and the term acute delirium to designate a specific delirium, is, to say the least, unfortunate.

tial particulars from those of delirium save that they are less acute and the course of the disease far more prolonged. In confusional insanity—the *Amentia* of Meynert, the *Verwirrtheit* of other German writers—there is the same presence of illusions and hallucinations, the same marked confusion and incoherence, but cerebral activity is never aroused to the same high pitch, and while delirium lasts from a few hours to a few days or more, confusion may last two or three months or more. The various forms of confusion are closely allied to each other, just as are the deliria, and no sharp distinctions can be drawn between them. However, special forms may bear the impress of their causation. Thus a confusional insanity following typhoid fever presents a somewhat different clinical picture from the confusional insanity of alcohol or lead poisoning, and yet in all essential particulars they are identical.

Every now and then we meet with cases in which an infection, poisoning, or profoundly debilitating cause, is followed by mental confusion, but in which the confusion is tinged with dulness and hebetude, and in which little by little mental obtusion becomes more and more pronounced until finally the faculties are completely in abeyance. Such a case forms one of stupor or so-called stuporous insanity, or acute dementia. Simple stupor, as is well known, does not make its appearance suddenly. Generally there is a prodromal period of several days or weeks during which the patient suffers from more or less marked mental confusion, attended, it may be, with excitement or with depression. As in the beginning of confusional insanity, the patient at first suffers from insomnia, is worried and afraid and is unable to think clearly. Soon confusion makes its appearance. There is loss of the proper appreciation of the surroundings. As in confusion, the patient believes himself to be in a strange place and does not properly recognize the persons about him. He is also distinctly hallucinatory, and up to this point the case resembles one of confusional insanity without much excitement. Little by little mental obtusion, noticed in the beginning, becomes more and more marked, and soon the loss of the power to ap-

preciate the surroundings becomes so profound that the patient lies motionless in bed, oblivious to everything about him. There is now no longer confusion, but instead, a more or less complete suspension of mental action.

It would be out of place here to dwell further upon the symptoms of stupor. I wish merely to emphasize the fact that confusion and stupor are closely related clinical forms. It is indeed at times impossible to accurately characterize a given case. In the first place stupor may occur as an episode of confusional insanity, and secondly cases are met with which occupy such an intermediate position that we are obliged to term them cases of confusion with stupor or stuporous confusion. What is true of the inter-relation of confusion and stupor, is also true, I need hardly say, of the inter-relation of delirium and confusion. Every now and then it happens that a case beginning as a simple delirium merges into one of confusion, and it is also true that during the course of a confusional insanity, episodes of more or less active delirium may occur. Clearly, delirium, confusion and stupor are closely related clinical forms and they may be considered as constituting a group of mental affections by themselves, separate and distinct, as we will see, from other mental disorders. I will not here speculate as to the cause of delirium, confusion or stupor. A sufficient hint is afforded us in the clinical history. We have at once suggested to our minds the action of bacteria, of bacterial toxins and of other poisons upon the cortex. It is probable that in delirium we have especially and essentially such an action, while in confusion and stupor we have the added factor of exhaustion.

It is necessary finally in connection with delirium, confusion and stupor, to emphasize two important facts. The first is that in these affections the emotional state plays only a secondary and unimportant rôle. In delirium and confusional insanity, the emotional state is frequently one of fear and depression, though anger and exaltation may also be noted. The two phases of the emotions may occur as varying episodes in the course of the affection, or the emotions may be feebly or not at all aroused. As far as the emotions

can be studied in stupor, the same statements hold true. We must conclude, therefore, that the emotions bear no relation of significance to these affections and that for purposes of diagnosis and classification, the emotional state in delirium, confusion and stupor must be disregarded. To this fact which is of the greatest importance to the clearness of the interpretation of insanity, I will later return. The second point is that in this group of mental affections, heredity plays an unimportant and secondary rôle or no rôle at all. It is doubtless true that persons of a neurotic make-up, or of a neurotic ancestry become delirious and confused more readily than those of normal organization, but there is a striking difference in the history of heredity in this group, and in the group of affections which we will next consider.

In melancholia, mania and circular insanity, we have a group of affections which are most closely related. The identity of the etiology of melancholia and mania, the great rôle played by heredity (estimated by Kraepelin at 80%), the fact that both affections occur especially in persons of the emotional and excitable, the poetic and artistic temperament, that they both occur by preference in early adult life, that they both present similar prodromal factors, that each runs a course of gradual increase, maximum intensity and final subsidence, that each presents in its course a phase which is the complement of the other, that in each the emotional state dominates the entire picture, that they both tend in their individual attacks to recovery, that each tends to recur, that opposite phases of melancholia and mania are found in the same individual, and finally that cases are met with in which the elements of both phases are present at the same time (the so-called mixed form of Kraepelin), can leave no doubt in our minds as to the close relation between the two disorders. Indeed, I do not myself hesitate for a moment to fully accept the interpretation of Kraepelin, that they really constitute *one* affection. We can, I think, with perfect propriety, speak as does Kraepelin, of "Manisch-depressive Irresein." A simple mononym, expressive of this idea, is greatly to be desired.

That the melancholia-mania syndrome differs radically from the delirium-confusion-stupor syndrome, every thinking alienist will at once admit. It is not necessary, before this audience, to recite on the one hand, the symptoms of mania—to recall the expansive emotional state, the increased rapidity in the elimination of ideas, the abnormal increase of association, the absence of hallucinations, the fleeting expansive delusions and the physical restlessness; nor on the other hand is it necessary to recall the symptoms of melancholia with its emotional depression, its psychic inhibition, its depressive delusions, in order to show how widely the symptom-group of melancholia-mania differs from delirium, stupor and confusion. It is perfectly true, of course, that every now and then, delirium, confusion and stupor occur as episodes during the height of a mania or melancholia, but they are merely episodes and nothing more. They are to be looked upon as symptoms superimposed upon the mania or melancholia proper and dependent upon accidental or secondary causes, such, for example, as exhaustion. The melancholia-mania syndrome is distinguished by the great factor of heredity, the dominance of the emotional state, its wavelike course, its relative lucidity as compared with delirium and confusion, and by its tendency to recurrence.

In melancholia-mania, we have an affection in which phases of depression are frequently succeeded by phases of exaltation, and in which, while the tendency is to recovery from individual attacks, the disease repeats itself in recurring waves. In paranoia, on the other hand, we have, in the typical and completely developed form, a disease in which a phase of depression extending over many years is at length followed by a phase of expansion, likewise of many years' duration, the two phases together dominating a great part of the life of the individual and terminating not in recovery, but in an increasing dementia. In paranoia, as we most frequently see it, we find a history of prolonged mental depression and hypochondriasis, together with the gradual evolution of depressive delusions, especially delusions of persecution, and and after some years this condition is succeeded by an expan-

sive stage, the so-called transformation of the personality, and characterized by delusions, expansive in character. It is impossible to here discuss paranoia in any but the most general terms. I need not recall to your minds how greatly individual cases vary in their details, that some cases progress as far as the expansive stage, and that others still are incomplete in their development—perhaps have not been observed for sufficiently long periods—but notwithstanding, all cases of paranoia agree in this essential feature, namely in the existence of systematized delusions extending over many years. It is also out of place here to enter into a discussion of the various forms of paranoia, the simple typical hallucinatory form, the mystic form, the litigious form, or of the form termed by Magnan, the insanity of the degenerate. It is clear to me that these forms belong together, that they are well grouped under the one head, paranoia, and that we must assign to paranoia a definite place in our classification.

Clearly melancholia-mania and paranoia, no matter what their pathology, are to be regarded as degenerations, and when we look for an allied group of affections also degenerative in their nature, the neurasthenic insanities at once suggest themselves. The neurasthenic insanities are among the most interesting with which we have to deal, and it seems to me that a correct interpretation of every one of the forms is to be found in the study of simple neurasthenia itself. Nervous exhaustion is an affection which may supervene in individuals who are otherwise perfectly normal. It may result, as is well known, from unphysiological living, overwork, overstrain, and other factors which induce chronic exhaustion. It is an affection to which every one is liable, those of normal as well as those of pathological heredity. The symptoms of neurasthenia as ordinarily met with, are those of chronic fatigue, and I have upon various occasions applied to it the term of the *fatigue neurosis*. I need not dwell upon the various fatigue pains and aches, the motor weakness, nor upon the various visceral disturbances met with in this affection, but I will pass on at once to the consideration of the psychic phenomena. At the very outset of our inquiry we meet the symp-

tom of ready exhaustion—of marked diminution in the capacity for sustained intellectual effort. The attempt to do mental work brings on more or less rapidly the signs of fatigue. Soon there is difficulty in sustaining and concentrating the attention, and at the same time there is a marked diminution in the spontaneity of thought. When the condition is pronounced and confirmed, the patient becomes irritable, nervous, lacks confidence in himself, betrays indecision regarding trivial matters, and is often emotional to an unusual degree. His equilibrium is readily disturbed; a play at the theatre or a newspaper account of a murder may provoke him to tears, or a trivial incident may provoke him to unusual annoyance or anger. In other words, added to the symptom of ready exhaustion we have that of deficient inhibition. His lack of confidence in himself may grow into a feeling of timidity; a man forceful and aggressive loses the readiness with which he arrives at decisions, loses in will-power and may even become chronically afraid. Weakness, indecision and fear are closely associated, and it is not surprising that a man in a condition of chronic exhaustion should become morbidly afraid. How the fear of neurasthenia manifests itself, it is hardly necessary for me to point out in detail. It manifests itself in many ways. There may be present a vague generalized sense of being afraid, or there may be present isolated, spontaneous attacks of generalized fear—a fear accompanied by marked outward physical signs. In such attacks, the face becomes pale, the heart palpitates, the pulse is small and rapid, the respiration hurried, there may be a cold sweat upon the body, and the patient may sink from weakness upon a chair or upon the ground. Indeed, if the attack be intense, there may even be relaxation of the sphincters. In other cases the fear, instead of retaining a general character assumes a special form. If, in addition to being neurasthenic, the patient be also neuropathic, *i.e.*, if there be in him the elements of nervous degeneration, hereditary, congenital or acquired, some pathological association may be formed in the patient's mind, so that the emotion of fear becomes linked with certain relations to the environment. This

to my mind is the most probable explanation of the origin of the various phobias—agoraphobia, claustrophobia and the like. For their establishment, two factors appear to be necessary, neurasthenia and neuropathy. Persons otherwise normal who acquire neurasthenia, do not acquire the special fears.

A similar explanation applies also to the origin of *folie du doute*. The madness of doubt is in reality the insanity of indecision and I believe it to be a neuropathic exaggeration, so to speak, of the indecision which is normally seen in ordinary neurasthenics. That profound neuropathic elements, hereditary or acquired, are necessary for its formation, there can, I think, be no doubt. To me the term *insanity of indecision* appears to be better than *folie du doute* or obsession of indecision, and it is the one which I am in the habit of employing.

A somewhat similar explanation, I believe, applies to so-called insanity with irresistible impulse. That the inhibition of the neurasthenic is deficient, we have already seen, and that it should manifest itself in various bizarre and erratic forms in persons who are also of neuropathic organization, is not surprising. The normal brain is constantly eliminating impulses which are constantly restrained or diverted into special channels. In the neuropathic neurasthenic, these impulses are not only no longer restrained, but manifest themselves as pathological associations of movement in relation to the environment. To my mind, the term *insanity from deficient inhibition* is better than obsession, *Zwangsvorstellung*, imperative idea, or insanity with irresistible impulse. The pathological association which gives birth to the impulse, is formed in the same manner as are numerous other, often irrelevant, associations in the normal mind, but in the latter such associations are repressed or inhibited and give no outward manifestation of their existence, while in the neurasthenic neuropathic subject, they are given motor expression as rapidly as they are formed.

The psychic symptoms observed in the simple neurasthenia of non-neuropathic individuals offer also an explan-

ation of so-called aboulie insanity or as I prefer to call it, *insanity from deficient will*. The condition is closely allied to the insanity of indecision and is characterized by the inability of the patient to perform some special act or acts which are as a rule simple in themselves, and which are habitually performed by normal persons without hesitation and even subconsciously; *e.g.* the inability to rise from a chair, to walk forward or in a given direction, or to ascend a certain stairway, or perform some other act equally simple, but concerning which some pathological association has been formed.

The neurasthenic insanities, it is quite evident, constitute a well-defined group by themselves, the fourth in our scheme of classification. It is now necessary to add a fifth group consisting of dementia.

It is hardly necessary to detail the symptoms of simple dementia in order to justify its claim to a position in our nosology. There are present the signs, more or less pronounced, of mental loss, incapacity for ordinary mental work, lack of precision and clearness, errors in simple statement, in writing and in figures, impairment of memory, especially for recent events, together with attendant degeneration in habits, dress and conduct. Dementia may exist as a simple and uncomplicated condition and is sometimes seen in its pure and typical form in old age. More frequently it is attended by hallucinations and delusions as in the dementias of puberty, the dementia of paresis, of gross organic disease of the brain and in so-called terminal dementia. To these forms I will call attention in their proper places.

The five groups of mental affections which I have thus far considered, I regard as simple or elemental forms of insanity. They are:

I. Delirium, confusion, stupor.

II. Melancholia, mania, circular insanity, (melancholia-mania).

III. Paranoia.

IV. Neurasthenic Insanities.

V. Dementia.

They all of them present distinctive features and if we

keep them clearly separated in our minds, the interpretation presented by the other phenomena of insanity becomes relatively easy.

We must next turn our attention to insanity as it is related to the various epochs of life; namely, infancy, puberty, early adult age, mature adult age, middle age and old age.

The first epoch, infancy, is that period of life which extends from birth to puberty. As is well known, insanity is but rarely met with during this epoch. We are all of us familiar, however, with the occurrence of delirium in children. Every general practitioner notes the occurrence of delirium in connection with the exanthemata and occasionally with fright and shock. It is noticed at such times that the child is illusional, hallucinatory and confused, and it may also manifest fragmentary delusions generally of a character associated with fear. Prolonged delirium may also be noted in children during the continuance of febrile affections; and delirium may also occur as a post-febrile manifestation just as it does in the adult. Prolonged deliria, either febrile or afebrile are, however, infrequent in children and in very young children quite rare. Long-continued mental confusion comparable to confusional insanity as it is found in the adult, is likewise rare. Stupor is met with, and in the experience of the writer, though rare, is somewhat more frequent than prolonged confusion. Other mental affections, such as melancholia, mania and paranoia are so rare as to be almost unknown. This fact doubtless bears a relation to the mental development of the child. Complex mental disorders are not yet possible, and certain it is that the influence of heredity does not make itself felt in a decided way until after puberty or adult life is reached. We can, however, every now and then detect in a child the elements of the melancholia-mania temperament. For instance, a child is unreasonably afraid, excessively shy, abnormally self-conscious, self-distrustful, preternaturally conscientious; perhaps it confesses imaginary sins or makes extravagant or premature religious protestations, or now and then manifests religious exaltation or excitement. Suicide in children, we may remark in passing,

does not bear the same relation to melancholia as it does in the adult. It more frequently results from fear of punishment, wounded pride, shame or cruel treatment. In some cases, however, no motive can be discovered, and it is possible that these are due to mental disease.

To briefly summarize, the epoch of infancy is characterized by a tendency to delirium, rarely to confusion or stupor. The melancholia-mania syndrome does not exist, and is represented, if at all, merely by peculiarities of conduct and temperament such as we have briefly outlined. Paranoia likewise does not exist. The neurasthenic insanities are met with extreme rarity. The dementias also are rare. It is hardly necessary before this association to draw the distinction between the insanities of infancy and idiocy and imbecility. Idiocy and imbecility are, roughly speaking, quantitative defects, are attended for the most part by gross morphological and pathological changes, and are not insanities. The insanities embrace changes in mental phenomena which are essentially qualitative, though they may also be quantitative.

When we turn to the period of puberty, we come to an epoch which to alienists is exceedingly interesting. We now have deliria both febrile and afebrile represented. We may also have confusion and stupor. Mania and melancholia are rare, though they become evident as adult life is approached. It is, however, the dementias of puberty that are of special interest. Indeed, they may be said to especially characterize this epoch of life. They may be grouped under the general term of precocious dementia or dementia præcox. The debt that we owe for their recognition to Hecker, to Kahlbaum, to Kraepelin, and to others, I cannot go into here. I can only briefly state my own interpretation. Dementia præcox is characterized by the symptoms of a dementia usually progressive, to which are added in a variable degree the elements of depression or exaltation, with fragmentary or more or less systematized delusions. It is a disease of slow progress. The initial changes consist of neurasthenoid symptoms with hypochondriacal and melancholic depression, of difficulty in performing the allotted tasks of school, and of

inability to acquire new ideas and to properly elaborate them. Inattention, indifference, absence of spontaneity, lack of interest, more or less rapid retrogression in class standing, next ensue. Gradually the thoughts become slow, disconnected and disordered. Illusions, hallucinations, transient delusions make their appearance, and now sudden flights from home or school force the attention of friends and relatives to the condition of the patient. It is not necessary to trace this familiar picture in its details, suffice it to say that as the dementia progresses, the elements of depression are gradually succeeded by those of expansion. The latter, especially in the younger patient, may be limited to causeless laughter, boisterous conduct, extravagant gestures or erotic manifestations. In other patients, especially in older ones, the expansive elements may be evidenced by expansive delusions, fragmentary or systematized. The depressive and expansive stages are frequently separated by well-marked periods of transition in which depressive and expansive elements are for a time commingled.

The various forms of dementia præcox separate themselves clinically into three forms; *first*, a dementia with the addition of elements of depression and expansion, the latter being on the whole ill-defined; *secondly*, a dementia with the addition of the elements of depression and expansion, the latter being more pronounced and better defined, together with special motor disturbances—convulsive phenomena, spasm of muscles, cataleptoid attitudes, automatism, etc.; and *third*, a dementia with marked and well-defined phases of depression and expansion together with well-formed delusions more or less systematized. To the first and second forms, Kahlbaum has applied the terms respectively of hebephrenia and katatonia, and to the third, Kraepelin has applied the term dementia paranoides. It is not always possible to draw sharp lines of distinction between the various forms; thus motor phenomena transient in character may be observed in a case otherwise deserving to be classed under hebephrenia, and slight degrees of automatism may be observed in cases otherwise coming under the head of dementia paranoides.

The differentiation, however, between the various forms holds good for the great mass of cases. As Pickett<sup>2</sup> has shown, in the younger cases, dementia præcox is apt to assume the form of hebephrenia; in those slightly older, the form of katatonia; and in those still older, the form of dementia paranoides. Let me emphasize again, that in all of these forms, in addition to the dementia, a wave of depression and of exaltation is present, though in hebephrenia the altitude of this wave may be limited. Its altitude becomes progressively greater as we pass through katatonia to dementia paranoides. The delusions also which are fragmentary in hebephrenia, still disconnected in katatonia, become finally more or less systematized in dementia paranoides. Doubtless this fact bears a direct relation to the greater intellectual development of the older patients.

The forms of insanity, therefore, which especially characterize the period of puberty are the precocious dementias:

Hebephrenia.

Katatonia.

Dementia paranoides.

When we turn our attention to the mental affections of early adult life, we may again, as in infancy and pubescence, meet with delirium, confusion and stupor. However, this period—the years from twenty to thirty—is essentially the period in which acute melancholia and acute mania are met with. It is the age of great depression and of great expansion, and this is not surprising when we consider the peculiar emotional and intellectual condition of this period of life—its hopes and fears, its poetry and illusions, its ideals and realities, its loves and disappointments.

It is perfectly true that a dementia præcox may be noted in early adult life, or that a life-long paranoia may have its inception at this period, and yet neither fact invalidates the statement that early adult life is especially the period of the melancholia-mania syndrome.

When we turn our attention to mature adult life, we find that while delirium, confusion and stupor may be met with,

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<sup>2</sup>Journal of Nervous and Mental Disease, August, 1901.

and while mania and melancholia, especially its recurrent attacks, may be observed, the period of mature adult life is especially that of chronic delusional insanity—of paranoia. Under the term paranoia, I believe that we should include, as I have already stated, all the forms of systematized delusional insanity. To limit its conception as does Kraepelin to the insanity of the degenerates of Magnan, and to relegate all of the hallucinatory paranoias to the group of dementia paranoides, is to drive us into the absurdity of regarding as insanities of pubescence, cases beginning at thirty-five or forty-five years of age or later.

When we turn to the insanities of middle life, we find that the common form met with is a melancholia, and this melancholia differs in some particulars from the melancholia of early life. Mania, rarely, if ever, is met with in middle life, and Kraepelin, who employs the term "*Manisch-depressive Irresein*" for the melancholia-mania syndrome, reserves the term melancholia exclusively for this melancholia of later life. It is a melancholia which is of longer duration—many months or even several years—and offers a much less favorable prognosis.

The insanities of old age are well embraced under the term senile dementia. This senile dementia may resolve itself into several forms; first, simple mental loss, simple dementia; secondly, a dementia which is complicated with hallucinations and illusions and with delusions based upon them—in other words, a dementia with confusion; the confusion may at times give place to episodes of delirium or of stupor. Thirdly, the dementia may be complicated by delusions somewhat systematized and crudely resembling paranoia, so-called senile paranoia.

Thus far we have considered the subject of insanity from two points of view; first we have resolved insanity into its simple or elemental forms; secondly we have applied these forms in a consideration of the various epochs of life. It is now necessary in order to complete our conception of insanity to approach it from still another point of view, namely, that of internal medicine. We must consider the relation

which insanity bears to the various infectious diseases, the intoxications, the diatheses, the visceral diseases, the diseases of the nervous system, and to pregnancy, the puerperium and lactation.

When we turn our attention to the acute infectious diseases as represented by typhoid fever, influenza, pneumonia, etc., we find that the common forms of mental disorders associated with or following these affections are delirium, confusion and stupor. The chronic infectious diseases as represented by syphilis, tuberculosis, malaria and pellagra, are somewhat similar in their relation to insanity, though each presents important special symptoms. Thus, in recent syphilitic infection there may be delirium with excitement, though this is rare; confusion is equally so, while syphilitic somnolence or stupor is met with not infrequently. Chronic insanity, due to syphilitic lesions is excessively rare. However, in gross and extensive syphilitic lesions of the vessels and membranes, a dementia may ensue, but this in no way differs from dementia due to other coarse organic disease of the brain, such as tumor, chronic meningitis, etc. It in no way resembles paresis. In tuberculosis, the euphoria, so usually present, may be replaced by mental depression with suspicions of poisoning, distrust of relatives and friends, painful hallucinations and persecutory delusions. At times, though less frequently, the mental disturbances may assume the form of outspoken delirium or of pronounced confusion. In malarial insanity, we find represented delirium, confusion and much more frequently stupor; the latter resembles the post-febrile stupor of typhoid and other fevers, save that it is not infrequently associated with convulsions which may be epileptic or tetaniform. In chronic malaria there may be hebetude, confusion with depression, and there may be more or less marked dementia—so-called “malarial paresis” or “malarial pseudo-paresis.” In pellagra we are told that delirium, confusion and dementia obtain, especially the latter, and it is probable that these states are associated with painful delusions, as the patients frequently seek death by drowning.

In the insanities of intoxication: alcohol, lead, morphia

and cocaine, we again meet with mental disturbances in which delirium, confusion and stupor or dementia are represented in varying degrees. For example, alcoholic insanity is separable first into alcoholic delirium, so-called delirium tremens; second, alcoholic confusion, so-called alcoholic confusional insanity; third, alcoholic stuporous insanity or alcoholic dementia. The alcoholic dementias, we may say in passing, are separable into simple alcoholic dementia, alcoholic dementia with systematized delusions (so-called alcoholic paranoia) and alcoholic dementia resembling paresis. Thus:

Delirium (delirium tremens).

Confusion (alcoholic confusional insanity).

Stuporous insanity (alcoholic dementia).

Simple alcoholic dementia.

Alcoholic dementia with systematized delusions (alcoholic paranoia).

Alcoholic dementia resembling paresis (alcoholic paresis).

Similar facts are presented by lead. There is a lead delirium and confusion and a lead dementia. Lead dementia again resembles alcoholic dementia in that it presents forms resembling crudely paranoia and paresis. I will not take time to pursue this parallelism into the mental disturbances caused by morphia and cocaine. Suffice it to say that if the abuse of these drugs has gone so far as to produce insanity, the latter manifests itself in the form of deliria, confusions and dementias. It need hardly be added that various special symptoms, dependent upon the poison which has been taken, are generally present. Thus in alcoholic delirium there is a marked predominance of visual hallucinations; in morphia and opium, of hallucinations of both sight and hearing; and in cocaine, of hallucinations of the cutaneous sensibility.

When we consider the diathetic diseases, rheumatism, gout and diabetes, we find that the type of mental disorder presented is again that of delirium, confusion and stupor. Delirium and confusion are especially noted in relation to gout, and the delusions are as a rule of a depressive and painful character. In diabetes it is confusion and especially stupor which may eventuate in diabetic coma, which characterizes the clinical picture.

In malignant disease and the grave visceral diseases, we again find that the picture is that of delirium and confusion, and at times of mental loss. The confusion, it must be added, is dominated by depressive and painful delusions and hallucinations. Of this, the insanity occasionally observed in connection with Bright's disease, is a good example.

The diseases of the nervous system are conveniently separated into the organic and functional diseases. With a single exception, organic diseases of the brain and cord are rarely accompanied by mental disturbances, and if the latter do make their appearance they present as a rule the symptoms of gross organic dementia. The exception, however, is most important and refers to paresis. In paresis we have a wasting or degenerative disease of the brain closely allied to the degeneration of the cord and nerves in locomotor ataxia. Paresis is indeed nothing more nor less than tabes of the brain. I need not speak here of its symptoms, of its initial wave of depression, of its later wave of expansion, and of its progressive mental deterioration. I wish merely here to emphasize its position in our scheme of classification as an organic nervous disease attended by mental symptoms.

Functional nervous diseases are not infrequently complicated by mental disorders. We need cite only the familiar insanities met with in epilepsy. Delirium, often sudden and violent, may occur during an epileptic attack or may supplant it, constituting in the latter instance the so-called psychic or larvated epilepsy. At times confusion replaces the delirium, and at other times stupor may occur. How epilepsy, if long-continued, may eventuate in dementia, we also know. When we turn our attention to hysteria, we again call to mind the occurrence of delirium and confusion during hysterical attacks, while stupor, so-called hysterical coma, is also a familiar picture. Every now and then in bad and long-standing cases of hysteria, more or less marked mental degeneration, characterized by distressing and painful visceral illusions, may be noted. The patient complains of endless ailments; makes round after round among physicians, insists upon unnecessary examinations and repeated surgical interference, craves

sympathy, is only satisfied when she is under a physician's care,—in short, her mental depression, visceral hallucinations and the delusions based upon them, lead her to make illness the business of her life.

Insanity is rather a rare complication of other functional nervous affections. Thus, chorea is rarely complicated by delirium or confusion; at times painful hallucinations and delusions are present.

When we turn to pregnancy, the puerperium and lactation, we again meet with mental disorders which are to be relegated to the group of delirium, confusion and stupor. If the mental disturbance of pregnancy approaches actual insanity, we note mental weakness, distressing hallucinations and painful delusions based upon the latter. In the insanities of the puerperium, we note delirium (mis-called puerperal mania), confusion and stupor. The mental disorders of lactation on the other hand resemble the less active form of mental confusion with depressive delusions met with during pregnancy.

The above brief résumé of the relation of the various visceral and general diseases and states to mental disorders is, of course, very imperfect. I am aware that in such a cursory review, an outline only can be given. It is sufficient, however, to justify a number of important conclusions.

First:—All of the mental disorders which result from the infections, the intoxications, the diatheses, the visceral diseases, the diseases of the nervous system, pregnancy, the puerperium and lactation,—in short from all of the diseases and morbid physiological states,—belong to the symptom-group of delirium-confusion-stupor-dementia. How closely related the various forms of this group are, we have already seen. Indeed, delirium, confusion and stupor are largely interchangeable terms possessing a certain degree of equivalence, and it must depend largely upon the activity of the morbid process as well as upon its character as to which of these forms is present in a given case. That secondary differences of symptoms, dependent upon the nature of the infection or

the special poison that has been ingested, are present, goes without saying, but these differences in no way affect the truth of the general statement.

Second:—The melancholia-mania syndrome bears no relation to the various infections, intoxications or visceral diseases. Neither mania nor melancholia ever results from them. Mania and melancholia are diseases primarily of the nervous system,—*neuroses* so to speak,—and are largely hereditary.

Much confusion has arisen from the loose and unscientific use of the words mania and melancholia, and in this respect alienists, neurologists and general practitioners have alike been guilty. To speak of a delirium as a mania because it happens to be attended by excitement, is certainly a gross misuse of terms and cannot be too strongly condemned. To designate a confusional insanity as a melancholia, merely because the delusions are distressing or painful, is equally unscientific and reprehensible. To say that a melancholia is caused by typhoid fever or that acute mania is caused by the abuse of alcohol, is to utter nonsense. Mania and melancholia are phases of a special syndrome which bears no relation to such causes. When a mania or melancholia actually occurs in a person who has suffered from such causes, the relation is to be regarded as accidental, or at most that the antecedent disease allowed the neurosis to become manifest, but was not itself a cause. I venture further to say that such coincidences are of the utmost rarity. Again, the relation of the internal medical diseases to paranoia is of like nature. Thus, we often speak of an alcoholic paranoia. The truth doubtless is that alcohol of itself can never cause paranoia; but on the other hand, it is probable that in persons already paranoiac by organization, the alcohol causing mental degeneration brings the paranoiac weakness to the surface; and this is no doubt also true of the action of other poisons. To conclude, melancholia-mania and paranoia,—as well as the neurasthenic-neuropathic insanities,—bear no relation to internal diseases. All causes, however, that are attended by persistent depression of nutrition or by degenerative changes in the nervous system, may favor their onset. The rarity of a clini-

cal history of a case of melancholia-mania even presenting such a relationship, is of sufficient significance.

Third:—The delirium-confusion-stupor syndrome may occur at all ages. Melancholia-mania and paranoia on the other hand are related to definite periods of life.

Fourth:—The delirium-confusion-stupor syndrome usually occurs independently; its forms may, however, occur as complications or episodes in any of the other affections.<sup>3</sup>

#### DISCUSSION.

Dr. J. H. Lloyd thought it was very evident that there was great dissatisfaction with our existing system of classifying insanity. As far as he could gather, Dr. Dercum was somewhat in accord with the expressed views of Kraepelin in putting mania and melancholia in one group of insanities. Kraepelin has recently expressed the conviction that mania and melancholia, if Dr. Lloyd did not mistake his expression, should be united and he even called it a maniaco-melancholic insanity. Dr. Lloyd thought with our present dearth of knowledge of true insanities it is perhaps somewhat premature to advance to this extreme position, because clinically the two diseases certainly seem to be very distinct, and yet all of us must have seen instances in which mania and melancholia alternate, or

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<sup>3</sup>In this connection we must bear in mind that the quiet and fixation of extreme melancholia attonita, so-called stuporous melancholia, must not be confounded with simple stupor. Simple stupor is an outgrowth and accentuation of confusion. "Stuporous melancholia" or melancholia attonita on the other hand, is not stuporous confusion, but a condition of extreme motor inhibition or akinesia, and is to be regarded as an accentuation merely of the general psychic inhibition of simple melancholia. The history of a given case will at once enable us to differentiate between this so-called melancholic stupor and simple stupor. We have ordinarily the history of a melancholia gradually deepening into one of greater and greater quiet until at last absolute immobility is reached. In true stupor we always have a history of preceding confusion extending over a number of days or weeks. Occasionally also symptoms are present which enable us to differentiate between the two conditions. Thus, in simple stupor there are every now and then evidences of confusion which occur as episodes in the course of the affection. In "melancholic stupor" on the other hand there are not infrequently observed automatism, cataleptoid attitudes and occasional outbreaks of melancholic agitation; the facies also present at times striking differences from those observed in simple stupor. However, a differentiation from the symptoms alone should not always be attempted.

It would be wise, in the interest of clearness, to avoid the use of such terms as stuporous melancholia, substituting therefor the expression melancholia attonita already in use, or better still to speak of melancholia with extreme akinesia.

in which one patient will at one time have maniacal symptoms and at another depressive symptoms, and in more chronic cases the disease may often assume that form known as the circular insanity, in which maniacal exaltation and depression alternate; the patient swings around the circle at long intervals. The one point he wished to make is that the so-called psychoses are often based upon a degenerative type. They are essentially seen in the hereditary and neurotic patients. In the old form of classification, especially the one which we derived from the Germans as represented by Krafft-Ebing, the psychoses are separated from the degenerative insanities. Dr. Lloyd had long been convinced there is some error in this. He had seen these so-called psychoses breaking out in the most distinct neurotic forms of insanity in patients who have in every way the hereditary stigmata.

Dr. Knapp said he was very glad that Dr. Dercum had gotten so far toward the position that he (Dr. Knapp) advocated two years ago before this society. Dr. Knapp was disposed to agree with Dr. Dercum very closely in the main outlines of his paper. Perhaps the only question that might come up would be in this maniacal-depressive insanity. Certainly many of the cases which are ordinarily spoken of clinically as either melancholia or as mania, as Dr. Dercum had hinted in his paper, might much more properly be put under the type of confusion, and certain others on more careful study would be brought into closer relation either with neurasthenic conditions in some of the cases of mental depression or with true paranoiac conditions. We are laboring under a very great disadvantage in our classification of insanity in that we have no definite and accepted clinical scheme of insanity on which to work. As we all know, all of us who have ever written a book on nervous diseases, or expect to write one, would agree in the fundamental methods of examining in cases of paralysis, anesthesia, etc., but neither Morselli, who has made the most complete attempt toward embodying in a text-book the clinical methods of examination in mental disorders, nor Ferrari, nor Kraepelin has given any absolute and generally accepted method of examination in mental affections. We must, furthermore, Dr. Knapp believed, hold just as definitely in the so-called mental disease, that is, those diseases of the brain in which the higher psychological functions are more involved, to the same rule we have in other diseases of the brain, namely, that the symptoms depend primarily upon the location of the lesion and only secondarily upon the actual pathological process. With that in view, if we establish some definite clinical scheme, if we hold to that fun-

damental rule which we hold in all diseases of the brain, Dr. Knapp though we shall get a more definitely established basis for our classification of the so-called mental diseases. In putting dementia as a separate group he thought we must acknowledge that dementia is invariably a terminal process—the result of some active process which for a time puts the association neurones of the cortex more or less completely out of function, a process from which the patient may recover, or which may be fatal, but which in either case is hardly a disease of itself, but the result of some of the other forms of mental disease.

He was also indisposed to agree fully with Dr. Dercum in his view that paranoiac conditions, or that conditions other than those of confusion and stupor, conditions of more definite intellectual disturbance, of delusions fairly well systematized, may not be the result of active intoxication as from alcohol. He thought we can recognize a definite alcoholic condition of systematized delusions and hallucinations unattended with confusion or stupor which is a temporary phenomenon passing away in a comparatively few weeks or months. Those cases are much less common than cases of confusion and stupor due to alcohol. In other respects, however, he thought we are indebted to Dr. Dercum for his very excellent classification, and in the main it is one to which Dr. Knapp would agree.

Dr. Mills said that the time was too short to discuss this paper, and he wished only to say with Dr. Knapp that he felt we are indebted to Dr. Dercum for his presentation of the subject, and also that while he, Dr. Mills, would concur with many of the points Dr. Dercum made in this paper, he would be inclined to differ with regard to some of them. He was not prepared to accept the idea that, at least clinically, melancholia and mania are to be included under the same group, agreeing in this respect with Dr. Lloyd, but he believed that Dr. Dercum's classification is a useful one, especially for students.

Dr. Fisher said he could not agree with this classification because he had not thought that a clinical classification is one we wanted. He believed that one based rather on the Krafft-Ebing idea is really the most easy to understand,—a most difficult subject anyway to enter into. His distinctions of pathological conditions and non-pathological conditions, and grouping of cases under each one of those heads, and of the fully developed brain and the partly developed, are more practicable. When we attempt a clinical classification we begin to differ at once.

Dr. Fisher did not believe that mania and melancholia

should be so closely united. In one there is almost no mental action, while in mania there is a rapid succession of ideas. In melancholia there is that painful condition of one or two ideas which causes tedium and tendency to suicide. Clinically these conditions seem different, and we know nothing of the pathology of the affections. They are probably dependent on some nutritional disorders. Most men differ on clinical points, and a classification of insanity on a clinical basis would lead to infinite confusion.

Dr. Dercum regarded the clinical classification as the clearest possible classification. As to including mania and melancholia in the same group when they occur in the same person, he did not see how we can escape from the clinical evidence that they are one and the same disease.

As regards Dr. Knapp's criticism of dementia, whatever we may think of dementia as a terminal stage it is met clinically and must have a place in a clinical classification. Furthermore, it is not always produced by other diseases, and we may have uncomplicated senile dementia.

In regard to paranoia, Dr. Dercum did not believe poisons ever produced systematized delusional insanity. If a man is paranoiac by nature and structure the destructive influences to which he may subject himself are factors which may develop that paranoia, but that is not saying that alcohol specifically produces paranoia. Dr. Dercum did not think alcohol causes paranoia directly; though it is one of many factors which may bring about paranoia in a person paranoiac by nature.